

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, CA 95814



April 18, 1997

ALL COUNTY LETTER NO. 97-25

TO: ALL COUNTY WELFARE DIRECTORS
ALL CHIEF PROBATION OFFICERS

REASON FOR THIS TRANSMITTAL

- ☐ State Law Change
- ☐ Federal Law or Regulation Change
- ☐ Court Order
- ☐ Clarification Requested by One or More Counties
- ☒ Initiated by CDSS

SUBJECT: FC 18 - NOTIFICATION OF AID TO FAMILIES WITH DEPENDENT
CHILDREN-FOSTER CARE (AFDC-FC) TRANSFER

The purpose of this notice is to transmit the new FC 18 (2/97), Notification of AFDC-FC Transfer. This new form will replace the ABCDM 215 that was discontinued by the AFDC program. The revised form will more accurately reflect Foster Care Program needs during an intercounty transfer. A copy of the new form is enclosed.

STOCK

The FC 18 is designated as a required form and no substitutes are permitted. State produced stock of the FC 18 is expected to be available in four to six weeks from the date of this letter.

CONTACTS

Counties that need a camera-ready copy of the FC 18 should call the Forms Management Unit at (916) 657-1907 or CALNET 437-1907.

If you have any questions regarding the form, you may contact your Foster Care Policy Analyst at (916) 323-1263.

Sincerely,

MARJORIE KELLY, Deputy Director
Children and Family Services Division

Enclosure

DATE: _____

NOTIFICATION OF AFDC-FOSTER CARE TRANSFER**SECTION A - SENDING COUNTY COMPLETES (PLEASE TYPE OR PRINT)**

CASE NAME	CASE NUMBER	CHILD'S PARENTS' NAME(S)
CHILD'S NAME	CHILD'S SOCIAL SECURITY NUMBER	DA CHILD SUPPORT NUMBER(S)
SENDING COUNTY ADDRESS		PAYEE NAME (IF FAMILY PLACEMENT - RELATIONSHIP)
RECEIVING COUNTY ADDRESS		ADDRESS OF FOSTER HOME OR INSTITUTION
DISCONTINUANCE DATE/END OF TRANSFER PERIOD		DATE JURISDICTION TRANSFERRED
TELEPHONE NUMBER: ()		

CURRENT PAYMENT AMOUNT:	BASIC RATE: \$	SPECIALIZED CARE RATE: \$	INFANT SUPPLEMENT: \$	CURRENT CLOTHING ALLOWANCE: \$	<input type="checkbox"/> INITIAL <input type="checkbox"/> ANNUAL:
AID PROGRAMS:	<input type="checkbox"/> FEDERAL FOSTER CARE <input type="checkbox"/> MEDI-CAL ONLY	<input type="checkbox"/> STATE FOSTER CARE <input type="checkbox"/> COUNTY ONLY	<input type="checkbox"/> EMERGENCY ASSISTANCE "NOT-TO-EXCEED DATE:" _____		

DOCUMENTATION:**ENCLOSED****N/A**

<input type="checkbox"/>	<input type="checkbox"/>	EA AUTHORIZATION DOCUMENTS [EA 1/ AGE SCREEN PRINT, OR OTHER DOCUMENTS]
<input type="checkbox"/>		SAWS 1
<input type="checkbox"/>		FC 2/JA 2
<input type="checkbox"/>		SOC 158A OR EQUIVALENT: _____
<input type="checkbox"/>		BIRTH CERTIFICATE/ALIEN STATUS DOCUMENTATION
<input type="checkbox"/>		SOCIAL SECURITY NUMBER DOCUMENTATION
<input type="checkbox"/>		FC 3/FC 3A - VERIFICATION OF DEPRIVATION
<input type="checkbox"/>	<input type="checkbox"/>	EVIDENCE SUPPORTING FEDERAL ELIGIBILITY [LINKAGE & DEPRIVATION]
<input type="checkbox"/>		COURT ORDER/AUTHORITY FOR PLACEMENT DOCUMENTATION
<input type="checkbox"/>		<input type="checkbox"/> DETENTION ORDER <input type="checkbox"/> DOCUMENTATION OF THREE JUDICIAL FINDINGS
<input type="checkbox"/>		<input type="checkbox"/> TRANSFER OF JURISDICTION <input type="checkbox"/> GUARDIANSHIP/RELINQUISHMENT PAPERS
<input type="checkbox"/>	<input type="checkbox"/>	PROPERTY OF MINOR/TRUST INFORMATION
<input type="checkbox"/>	<input type="checkbox"/>	INCOME OF MINOR: _____ TYPE: _____ AMOUNT \$ _____
<input type="checkbox"/>	<input type="checkbox"/>	INDEPENDENT LIVING PLAN
<input type="checkbox"/>	<input type="checkbox"/>	18 YEARS OLD AND OVER DOCUMENTS [MUTUAL AGREEMENT, SCHOOL VERIFICATION]
<input type="checkbox"/>	<input type="checkbox"/>	DHS6155 HEALTH INSURANCE QUESTIONNAIRE
<input type="checkbox"/>	<input type="checkbox"/>	APPLICATIONS PENDING (SSI/SSP)
<input type="checkbox"/>	<input type="checkbox"/>	FC 4
<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____

SOCIAL WORKER'S NAME	SOCIAL WORKER NUMBER	SOCIAL WORKER'S TELEPHONE NUMBER ()
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COMMENTS:

ELIGIBILITY WORKER'S NAME	ELIGIBILITY WORKER NUMBER	ELIGIBILITY WORKER'S TELEPHONE NUMBER ()
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SECTION B: RECEIVING COUNTY COMPLETES: (PLEASE TYPE OR PRINT)

<input type="checkbox"/> TRANSFER ACCEPTED	<input type="checkbox"/> TRANSFER NOT ACCEPTED - REASON:
<input type="checkbox"/> CASE ELIGIBLE - WILL BEGIN ON:	<input type="checkbox"/> CASE INELIGIBLE - REASON:

ELIGIBILITY WORKER'S NAME	ELIGIBILITY WORKER NUMBER	ELIGIBILITY WORKER'S TELEPHONE NUMBER ()
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DISTRICT OFFICE